

CERTIFICATE OF DEATH

00714
191

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3401-4</u>	
c. LENGTH OF STAY IN 1b <u>15 mo.</u>		d. STREET ADDRESS <u>3539 Juneway</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Highland Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Constanty Benicewicz (Benesch)</u>		4. DATE OF DEATH <u>1</u> <u>21</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Sailor </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sailoring Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Lillian T. Blair</u>		Address <u>Route 2, Box 237A Glen Burnie Md</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>420.0</u> (b) DUE TO <u>420.0</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 day 5</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Dis. Arter. Renal Dis.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>56</u> , to <u>1/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Carp J. Miller</u>		DATE SIGNED <u>1/22/57</u>
PHYSICIAN'S NAME (Type) <u>MAX D. MILLER</u>		ADDRESS (Street, city or town, state) <u>5226 Balto Nat Pike</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Russian Orthodox Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Cowan</u>		ADDRESS <u>901 Hollins St.</u>	24a. REC'D BY REGISTRAR <u>J. E. Dougherty</u>
		DATE <u>JAN 24 1957</u>	

RECEIVED

BUREAU V. S.

JAN 24 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

720

CERTIFICATE OF DEATH

00715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grifford-Savage Road</u>				d. STREET ADDRESS <u>Grifford-Savage Rd</u>			
3. NAME OF DECEASED (Type or print) <u>James Howard Bird</u>				4. DATE OF DEATH <u>January 29 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 22 1874</u>	
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Uriah Bird</u>				14. MOTHER'S MAIDEN NAME <u>Susan Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs L. Edgim Carr, Savage, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene legs</u> <u>450.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>10 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1950</u> to <u>1/29 1957</u> that I last saw the deceased alive on <u>1/28/57</u> and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.				ADDRESS (Street, city or town, state) <u>Lanell Md</u> DATE SIGNED <u>1/29/57</u>			
PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lanell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lanell Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed With Davidson</u> ADDRESS <u>Lanell Md</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>D. H. Fetters</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of coroner		12. Signature of medical examiner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of hospital		17. Signature of nursing home		18. Signature of other institution	
19. Signature of family		20. Signature of friends		21. Signature of neighbors	
22. Signature of community		23. Signature of church		24. Signature of synagogue	
25. Signature of mosque		26. Signature of other religious institution		27. Signature of other institution	
28. Signature of other institution		29. Signature of other institution		30. Signature of other institution	
31. Signature of other institution		32. Signature of other institution		33. Signature of other institution	
34. Signature of other institution		35. Signature of other institution		36. Signature of other institution	
37. Signature of other institution		38. Signature of other institution		39. Signature of other institution	
40. Signature of other institution		41. Signature of other institution		42. Signature of other institution	
43. Signature of other institution		44. Signature of other institution		45. Signature of other institution	
46. Signature of other institution		47. Signature of other institution		48. Signature of other institution	
49. Signature of other institution		50. Signature of other institution		51. Signature of other institution	
52. Signature of other institution		53. Signature of other institution		54. Signature of other institution	
55. Signature of other institution		56. Signature of other institution		57. Signature of other institution	
58. Signature of other institution		59. Signature of other institution		60. Signature of other institution	
61. Signature of other institution		62. Signature of other institution		63. Signature of other institution	
64. Signature of other institution		65. Signature of other institution		66. Signature of other institution	
67. Signature of other institution		68. Signature of other institution		69. Signature of other institution	
70. Signature of other institution		71. Signature of other institution		72. Signature of other institution	
73. Signature of other institution		74. Signature of other institution		75. Signature of other institution	
76. Signature of other institution		77. Signature of other institution		78. Signature of other institution	
79. Signature of other institution		80. Signature of other institution		81. Signature of other institution	
82. Signature of other institution		83. Signature of other institution		84. Signature of other institution	
85. Signature of other institution		86. Signature of other institution		87. Signature of other institution	
88. Signature of other institution		89. Signature of other institution		90. Signature of other institution	
91. Signature of other institution		92. Signature of other institution		93. Signature of other institution	
94. Signature of other institution		95. Signature of other institution		96. Signature of other institution	
97. Signature of other institution		98. Signature of other institution		99. Signature of other institution	
100. Signature of other institution		101. Signature of other institution		102. Signature of other institution	

RECEIVED

FEB 5 1957

BUREAU V. 3

MEDICAL CERTIFICATION

VS AIS (4)
1SM 9/5S

BUREAU V. S.

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

722

CERTIFICATE OF DEATH

00717

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> <u>Rural</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffers Nursing Home</u>			d. STREET ADDRESS <u>1</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MOLLIE KRAH BROWN</u>			4. DATE OF DEATH Month Day Year <u>January 10 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		
11. BIRTHPLACE (State or foreign country) <u>Catonsville, Md</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>JACOB KRAH</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT Address <u>James D. Brown Jr. Ellicott City Md</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive myocardial failure</u> <u>420.1</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left hemiplegia</u> DUE TO <u>Cerebral thrombosis</u> (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Dec. 1, 1956</u> , to <u>Jan. 10, 1957</u> , that I last saw the deceased alive on <u>Jan. 5, 1957</u> , and that death occurred at <u>6 P.</u> M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Donald E. Fisher M.D.</u> <u>Ellicott City, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>Donald E. Fisher, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>	
22d. LOCATION (City, town, or county) (State) <u>Alpha, Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F.C. Higinbotham, Ellicott City, Md</u>			
24a. REC'D BY REGISTRAR DATE <u>14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>			

CERTIFICATE OF DEATH

1957

BUREAU V. S.

JAN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00718

723

CERTIFICATE OF DEATH

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY Fulton Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton		c. LENGTH OF STAY IN 1b 6 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Highland		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simon Rest Home	
d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George W. Middle Cashell Last		4. DATE OF DEATH Month January Day 12 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 2, 1869
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11b. KIND OF BUSINESS OR INDUSTRY Own farm	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gustavus Cashell		14. MOTHER'S MAIDEN NAME Sarah Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT William C. Shoemaker		Address Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 72 hours 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>47</u> , to <u>Jan. 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 11</u> , 19 <u>57</u> , and that death occurred at <u>7:00A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		DATE SIGNED <u>1/12/57</u>	
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>		Address <u>Clarksville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 15/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marie Whitaker</u>		ADDRESS <u>Clarksville, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Marie Whitaker</u>		24b. REGISTRAR'S SIGNATURE <u>Marie Whitaker</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

BUREAU V. S.

JAN 17 1892

RECEIVED

724 CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home		STREET ADDRESS (If rural give location) 2907 Inglewood Ave.,	
3. NAME OF DECEASED: (Type or Print) Florence Crouse		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 28 1957	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Jan. 1, 1883
9. AGE last birthday: 74 yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: Unknown Shipley	
14. MOTHER'S MAIDEN NAME: Mary Cole		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No	
16. SOCIAL SECURITY NO. 220-18-4249B		17. INFORMANT & ADDRESS: Mrs. Edna M. Kleczynski-2907 Inglewood Ave.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pulmonary Edema (Congestive Failure)			1 day
ANTECEDENT CAUSE (B) Arteriosclerosis of Heart Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1/10, 1957 , to 1/28, 1957 , that I last saw the deceased alive on 1/26, 1957 , and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE Thas J. Wilby MD		DATE SIGNED 1/28/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/31/1957	NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
LOCATION (City, town, or county) Frederick Rd. Maryland		24. FUNERAL DIRECTOR ADDRESS Wm Cook-Blight, Inc 6009 Harford Rd.	
DATE REC'D BY LOCAL REGISTRAR 1-30-57		REGISTRAR'S SIGNATURE L. J. E. Laughery	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00720

Reg. Dist. No.

191

725

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Johns and Route 40 West Bound Lane				d. STREET ADDRESS Detour		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARMEN CASH DELAPLANE				4. DATE OF DEATH Month Day Year Jan. 14, 1957 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elementary School Supv.				10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME H. Frank Delaplane				14. MOTHER'S MAIDEN NAME Alice Cash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Personal Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing of Skull DIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Rt. Humerus and left Radius, Ulna and Humerus, Crushed Chest							INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision between passenger car and tractor trailer					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 9.30 A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) St. Johns lane & route 40 Howard Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George E. Burgtorf				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Harvill's Cemetery		22d. LOCATION (City, town, or county) (State) Ladysburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mervyn C. Duss				24. REC'D BY REGISTRAR Jan 18 1957		24b. REGISTRAR'S SIGNATURE J. E. Laughery	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

BUREAU A. I.

JAN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00721
191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 29 and St. Johns Lane				d. STREET ADDRESS Rt. 29		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GUY EDWARD GASTON				4. DATE OF DEATH Month Jan Day 6 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-1896		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) York, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Gaston				14. MOTHER'S MAIDEN NAME Ella Whitmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW 1		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. Julia Gaston, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Committuted Fracture of Skull Right DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Rt. Tibia, Fibula, Femur and neck of left femur							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian walked into left side of moving automobile					
20c. TIME OF INJURY Month, Day, Year 5.30 P.M. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Ellicott City Howard Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George E. Burgtorf				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-7-1957	
EXAMINER'S NAME (Type) George E. Burgtorf M D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-9-57		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) WOODLAWN, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. HIGGINBOTHAM, ELlicott City Md				24a. REC'D BY REGISTRAR 100		24b. REGISTRAR'S SIGNATURE J. E. Laughery	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

RECEIVED

JAN 8 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

727

CERTIFICATE OF DEATH

00722
141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Convalescent Retreat		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Convalescent Retreat		d. STREET ADDRESS 3101 Clifton Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Last GERMAN		4. DATE OF DEATH Month Jan. Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1866
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. W. Reed		14. MOTHER'S MAIDEN NAME Elizabeth Seymour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Edith A. Jahnigen		Address 207 Rollingdale Rd. (28)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor DUE TO (b) Arteriosclerosis - CV Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15 , 19 54 , to Jan 26 , 19 57 , that I last saw the deceased alive on Jan. 26 , 19 57 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED ACTUAL SIGNATURE Leon A. Kochman, M.D. PHYSICIAN'S NAME (Type) Leon A. Kochman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		24a. REC'D BY REGISTRAR J. E. Loughran	
24b. REGISTRAR'S SIGNATURE J. E. Loughran		DATE JAN 29 1957	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN

RECEIVED

728

CERTIFICATE OF DEATH

Reg. Dist. No.

0072395

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Nellie Middle Harrell Last Harrell		4. DATE OF DEATH Month January Day 8 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1885
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Middletown, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Cooley		14. MOTHER'S MAIDEN NAME Margaret Virginia Wilkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Brentie Wheatley, Washington, D. C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive - Cardio-Vas. Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insuff. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1st 1956 to Jan. 8th 1957 that I last saw the deceased alive on Jan. 8th 1957 , and that death occurred at 4:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Savage, Md. DATE SIGNED 1/10/57			
ACTUAL SIGNATURE Frank Shipley M.D.			
PHYSICIAN'S NAME (Type) Frank Shipley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 11, 1957	22c. NAME OF CEMETERY OR CREMATORY Savage Cemetery	22d. LOCATION (City, town, or county) (State) Savage, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert Donaldson Laurel Md.		24a. REC'D BY REGISTRAR DATE JAN 14 57	
24b. REGISTRAR'S SIGNATURE Al Search			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. OVERMAN

1917

DECEMBER

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daniels		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daniels	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle HAMPSON Last HENRY		4. DATE OF DEATH Month Jan. Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1884
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Watchman Cotton	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert S. Henry		14. MOTHER'S MAIDEN NAME Martha Henry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-6981	
17. INFORMANT Mrs. Ella Henry, Daniels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH. Immed. Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25/1957 to 1/28/1957 , that I last saw the deceased alive on 1/25/1957 , and that death occurred at 10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Gassaway M.D.		ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 1/28/57	
PHYSICIAN'S NAME (Type) William F. Gassaway M.D.		Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-31-57	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR JAN 31 1957	
		24b. REGISTRAR'S SIGNATURE Marie Shuter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 of this certificate should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WHEAT V. S.

AN.

RECEIVED

730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Isaiah</u> Middle <u>W.</u> Last <u>Holland</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Holland</u>		14. MOTHER'S MAIDEN NAME <u>Emma Burgess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W. #1</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fannie Chandler</u>		Address <u>700 Carroll St. Balt 17</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, Hypertension,</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, Cardiac Failure,</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 Jan 57</u> <u>5 Jan 57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4 Jan</u> , 1957, to <u>5 Jan</u> , 1957, that I last saw the deceased alive on <u>5 Jan</u> , 1957, and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. DEATH CERTIFICATE <u>Howard E Hall</u> M.D. <u>Agnewville, MD</u> 5 Jan 57 PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u> <u>SYKESVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth A. Haight</u>		24a. REC'D BY REGISTRAR <u>W. H. Hedrich</u>	
Address <u>Agnewville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hedrich</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 9 1957

BUREAU V. S.

731

CERTIFICATE OF DEATH

00726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott city				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Highland Manor				d. STREET ADDRESS 3259 Chestnut Ave			
3. NAME OF DECEASED (Type or print) First Sarah Middle M Last Kaiser				4. DATE OF DEATH Month January Day 30 Year 19 57			
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4 1877	9. AGE (In years last birthday) yrs 79	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 125 HOME			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN MILLER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT OLIVER A. KALBFUS		Address 3259 Chestnut Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 Hour 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/11 , 19 56 , to 1/30 , 19 57 , that I last saw the deceased alive on 1/28 , 19 57 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Max J Miller				ADDRESS (Street, city or town, state) 5226 Balt Nat Pike		DATE SIGNED 1/31/57	
PHYSICIAN'S NAME (Type) Max J Miller							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/2/57		22c. NAME OF CEMETERY OR CREMATORY NOLY REDEEMER		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Chas F. Evans & Son 118 W. Mt. Royal				24a. REC'D BY REGISTRAR FEB 4 1957		24b. REGISTRAR'S SIGNATURE J. E. Loughran	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 4 1957

RECEIVED

732

CERTIFICATE OF DEATH

00727

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1801 St Augustine</u>		e. STREET ADDRESS <u>1801 St Augustine Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>MARIAN</u> Last <u>LAYNOR</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland Springs, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert M. Bounds</u>		14. MOTHER'S MAIDEN NAME <u>Clara Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Miss Grace C. Layne</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Thrombosis</u> <u>422.1</u> DUE TO <u>Left ventricular failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Long standing hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myocarditis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 20, 1957</u> , to <u>Jan 20, 1957</u> , that I last saw the deceased alive on <u>Jan 20, 1957</u> , and that death occurred at <u>9 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1/21/57</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 23, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Melville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elbridge, Howard Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Son, Inc.</u>		24. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
ADDRESS <u>4905 York Road</u>		DATE <u>1/20/57</u>	

BUREAU V. S.

APR 10 1957

RECEIVED

733

CERTIFICATE OF DEATH

Reg. Dist. No.

00728
171

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edwards City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 mi. W. Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shapers Conv. Retreat</u>		d. STREET ADDRESS <u>4400 Gr. ... ave</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA ELIZABETH BLIGHT MORGAN</u>		4. DATE OF DEATH <u>Jan 5 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28 1869</u>
9. AGE (in years last birthday) <u>87</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cuba, South America</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Blight</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>68-152-953</u>	
17. INFORMANT <u>Wm. S. Morgan</u>		Address <u>5805 Kipling Court</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis CV disease</u> DUE TO (b) <u>4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>4</u> DUE TO (c) <u>4</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>56</u> , to <u>Jan 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1/5/57</u>			
ACTUAL <u>Dr. A. K. ...</u> M.D. <u>1-2-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. K. ...</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 8 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. ...</u>		ADDRESS <u>Co 4905 York Rd.</u>	24a. REC'D BY REGISTRAR <u>J. E. Loughran</u>
		DATE <u>1/8/57</u>	

BUREAU V. 3

JAN 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

734

CERTIFICATE OF DEATH

00729

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Balto. Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Schaefer's Nursing Home</u>				d. STREET ADDRESS <u>3023 Wylie Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR MAYNARD PATTERSON</u>				4. DATE OF DEATH Month Day Year <u>Jan. 30, 19 57</u>			
5 SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver (rtd)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Samuel Hanson Patterson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Pennington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Lula H. Patterson - 3023 Wylie Ave.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UREMIA</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
(b) <u>CHRONIC URINARY INFECTION</u>							
DUE TO							
(c) <u>BLADDER TUMOR</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARDIAC DECOMPENSATION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>10-22</u> <u>1956</u> to <u>1-30</u> <u>1957</u> that I last saw the deceased alive on <u>1-26</u> <u>1957</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter V Thorpe</u>				ADDRESS (Street, city or town, state) <u>COLUMBIA RD</u>			
DATE SIGNED <u>1-31-57</u>							
PHYSICIAN'S NAME (Type) <u>PETER V THORPE MD ELICOTT CITY, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jessops Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickens & Sons - Balto, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>1-31-57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. E. Laughery</u>							

BUREAU V. S.

FEB 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Illegals 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00730, 91

735

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> <u>rural</u>				c. LENGTH OF STAY IN 1b <u>7</u> <u>days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Browns Motor Court Rt. 40</u>				d. STREET ADDRESS <u>1114 Gregory Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>BERNARD J. ROSE</u>				4. DATE OF DEATH <u>1-26-1957</u> <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1910</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vending Machine - gr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vending Machine</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maxwell Rose</u>				14. MOTHER'S MAIDEN NAME <u>Mary Singleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>398-07-0207</u>		17. INFORMANT <u>Mr. B.J. Rose</u> Address <u>1114 Gregory Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO							<u>10 min.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO							<u>2 years</u>
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>George E. Burgtorf</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-26-1957</u>	
EXAMINER'S NAME (Type) <u>George E. Burgtorf M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 30, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. May Funeral Home, Cathedral Rd</u>				ADDRESS <u>Cathedral Rd</u>		24a. REC'D BY REGISTRAR <u>J. E. Langhorne</u>	
				24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

736

CERTIFICATE OF DEATH

Reg. Dist. No. 0073191

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schafers Convalescent Home		d. STREET ADDRESS 4219 Kenwood Ave.	
3. NAME OF DECEASED (Type or print) First AMELIA Middle C Last SENNER		4. DATE OF DEATH Month January Day 13th Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1873
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Godfried Grill		14. MOTHER'S MAIDEN NAME Dora ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Arthur H. Senner, 3242 Abell Ave, Baltimore, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARDIAC DECOMPENSATION (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ?		INTERVAL BETWEEN ONSET AND DEATH 6 HRS. 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 21, 1956 to JAN. 13, 1957 , that I last saw the deceased alive on JAN. 13, 1956 , and that death occurred at 5:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) COLUMBIA RD DATE SIGNED ACTUAL SIGNATURE Peter V. Thorpe M.D. ELLICOTT CITY, MD 1-14-57 PHYSICIAN'S NAME (Type) PETER V. THORPE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-16-57	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR 5305 Harford Road Baltimore, Md	
24b. REGISTRAR'S SIGNATURE J. E. Dougherty		DATE JAN 16 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 16 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 23 Film 30-1-10-53 et

737

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard County</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor Nursing Home</u>		STREET ADDRESS (If rural give location) <u>Route 15, Box 207, Baltimore 20, Md.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ROSALIE SINK</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 11 19 57</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 10, 1877</u>
9. AGE last birthday <u>79</u> yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Benedict Lextutis</u>		14. MOTHER'S MAIDEN NAME: <u>Barbara Bruzait</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Frank A. Jordan, Route 15, Box 200, Balto. 20</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Renal Disease - Hemip</u>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>			<u>2 yrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/1, 1956</u> to <u>1/11, 1957</u> , that I last saw the deceased alive on <u>1/11, 1957</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Max J. Lusk</u>		ADDRESS <u>5221 Balto Natl Rd</u>	
DATE <u>1/11/57</u>		M. D. <u>5221 Balto Natl Rd</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE, THEREOF <u>1-17-57</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE, REG'D BY LOCAL REGISTRAR <u>JAN 17 1957</u>		REGISTRAR'S SIGNATURE <u>J. E. Loughery</u>	
24. FUNERAL DIRECTOR <u>William Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1957

BUREAU V. S.

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1000213xv2

VS. A15ME(5)
5M 9/55

BUREAU V. E.

1957

RECEIVED

739

CERTIFICATE OF DEATH

Reg. Dist. No.

19✓

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Rural - West Friendship</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - West Friendship</u>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles</u> <u>EDWIN</u> <u>Thompson</u>				4. DATE OF DEATH Month Day Year <u>Jan</u> <u>7</u> <u>19-57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1866</u>		9. AGE (In years last birthday) yrs <u>90</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Warren R. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Lowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Mr Charles H. Thompson - West Friendship MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure, Arteriosclerosis generalized,</u> DUE TO (c) <u>bronchial pneumonia.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>19 34</u> <u>70</u> <u>Jan 19 57</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>19 54</u> , 19 <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7 Jan</u> , 19 <u>57</u> , and that death occurred at <u>6:45 P M</u> , from the causes and on the date stated above. DECEASED SIGNATURE <u>Howard E. Hall</u> ADDRESS (Street, city or town, state) <u>Sykesville, Md</u> DATE SIGNED <u>7 Jan 57</u> PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u> ADDRESS <u>SYKESVILLE, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT View</u>		22d. LOCATION (City, town, or county) (State) <u>Alpha, Howard Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur W. Wright - Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Alice Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION

1967

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
740
CERTIFICATE OF DEATH

00735

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) p. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS X2 Glenelg			
3. NAME OF DECEASED (Type or print) First Middle Last DEBRA ANN WALKER				4. DATE OF DEATH Month Day Year 1-29-57 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1956	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days 4 16	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Olney, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Shelton Walker				14. MOTHER'S MAIDEN NAME Geraldine Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Shelton Walker, Glenelg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lobar pneumonia, left lower lung DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 28, 1957 , to Jan 29, 1957 , that I last saw the deceased alive on Jan 29, 1957 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.				ADDRESS (Street, city or town, state) CLARKSVILLE, MD.			
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.				DATE SIGNED 1/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-57		22c. NAME OF CEMETERY OR CREMATORY Liberty Baptist		22d. LOCATION (City, town, or county) (State) Lisbon, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR DATE 31 1957		24b. REGISTRAR'S SIGNATURE Marie Whitaker	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

741

CERTIFICATE OF DEATH

00736/191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Daniels Road				d. STREET ADDRESS Daniels Road			
3. NAME OF DECEASED (Type or print) First IDA Middle EMMA Last WEBB				4. DATE OF DEATH Month Jan. Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-1984	
9. AGE (in years last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Loudon Co. Va.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Thomas W. Webb			
14. MOTHER'S MAIDEN NAME Gertrude Riley				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO None				17. INFORMANT Chas. T. Webb Ellicott City Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 5 year
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 11, 1950 to Jan. 17, 1957 , that I last saw the deceased alive on Jan. 17, 1956 , and that death occurred at 1:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE George E. Burgtorf M.D. PHYSICIAN'S NAME (Type) George E. Burgtorf M.D. Ellicott City, Md. 1-19-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR JAN 22 1957		24b. REGISTRAR'S SIGNATURE J. E. Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

742

CERTIFICATE OF DEATH

00737

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY <u>Harvard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittston</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilkes-Barre</u>			
c. LENGTH OF STAY IN 1b <u>10 mos.</u>				d. STREET ADDRESS <u>541 S. Tremont Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Simon Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rachel Anna Will</u>				4. DATE OF DEATH <u>January 14 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7 1873</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Doll</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Smutz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Robert S. Will, Union Park Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>10 YEARS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan 13</u> , 1957, to <u>Jan 14</u> , 1957, that I last saw the deceased alive on <u>Jan 13</u> , 1957, and that death occurred at <u>11:10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, MD. CLARKSVILLE, MD.</u>							
22a. BURIAL, CREMATION, or other disposal <u>burial</u>		22b. DATE THEREOF <u>Jan 17-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Evangelical & Woodstock, Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Norvaldson Laurel Md</u>				24a. REC'D BY REGISTRAR <u>Marie Whitaker</u>		24b. REGISTRAR'S SIGNATURE	

JAN 21 1957

RECEIVED
JAN 21 1957
BUREAU V. A.

743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cooksville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Williams</u>		4. DATE OF DEATH <u>Jan 22 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Asbury Williams</u>		14. MOTHER'S MAIDEN NAME <u>Ritty Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>219-16-3700</u>	
17. INFORMANT <u>Francis Williams - Cooksville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery, cerebral hemorrhage.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, hypertension</u> DUE TO (c) <u>Left hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1455</u> <u>70</u> <u>22 Jan 57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>Jan 22, 1957</u> , that I last saw the deceased alive on <u>Jan 10, 1957</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>23 Jan 57</u>	
PRINTED NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville, Howard, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 25 57</u> 24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. RIVIERA

701

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00739
190
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ham's Cabins				d. STREET ADDRESS Ham's Cabins			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle WILSON Last WILSON				4. DATE OF DEATH Month 1 Day 17 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 5 Days 17	IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John D. Wilson				14. MOTHER'S MAIDEN NAME Amelia Irby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-05-1949		17. INFORMANT Gertrude Fields Address 555 Edgewood Ave. Apt 1A N.Y. N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-21-1957		22c. NAME OF CEMETERY OR CREMATORY Blandford Cemetery Petersburg, Va.		22d. LOCATION (City, town, or county) (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				24a. REC'D BY REGISTRAR 1-23-57		24b. REGISTRAR'S SIGNATURE J. B. Williams	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 28 1957
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JAN 28 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

745

CERTIFICATE OF DEATH

Reg. Dist. No.

00740

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ELIJAH Middle WINSTEAD Last				4. DATE OF DEATH Month Jan. Day 31 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1909	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumbering		10b. KIND OF BUSINESS OR INDUSTRY Lumber Busoness		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-9497		17. INFORMANT Address Mrs. Clelia Winstead, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, idiopathic DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) peptic ulcers, healed cardiac asthma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 7-6- , 1956 , to 1-31- , 1958 , that I last saw the deceased alive on 1-9-57 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 1-31-57							
ACTUAL SIGNATURE Donald E. Fisher		M.D. Ellicott City, Md.		DATE SIGNED 1-31-57			
PHYSICIAN'S NAME (Type) Donald E. Fisher, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR FEB 4 1957		24b. REGISTRAR'S SIGNATURE J. E. Loughery	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

BUREAU V. R.

FEB 4 1957

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